

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042739</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lexington of Chicago Ridge</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>10300 Southwest Highway</u> <u>Chicago Ridge</u> <u>60145</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(708) 425-1100</u> Fax # <u>(708) 425-0779</u>		(Type or Print Name) _____	
IDPA ID Number: <u>363734823001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>05/27/91</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input type="checkbox"/> Charitable Corp.		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
IRS Exemption Code _____			
<input checked="" type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input checked="" type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other			
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>224</u>	Skilled (SNF)	<u>224</u>	<u>81,760</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>224</u>	TOTALS	<u>224</u>	<u>81,760</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>25,007</u>	<u>5,632</u>	<u>8,895</u>	<u>39,534</u>	8
9	SNF/PED					9
10	ICF	<u>32,733</u>	<u>3,028</u>	<u>578</u>	<u>36,339</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>57,740</u>	<u>8,660</u>	<u>9,473</u>	<u>75,873</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.80%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/4/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New ConstructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 49 and days of care provided 8,065Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	298,552	31,237	15,642	345,431		345,431		345,431		1
2	Food Purchase		293,602		293,602		293,602	(11,664)	281,938		2
3	Housekeeping	274,190	45,364		319,554		319,554	771	320,325		3
4	Laundry	71,098	23,565		94,663		94,663	(1,702)	92,961		4
5	Heat and Other Utilities			190,048	190,048		190,048	4,117	194,165		5
6	Maintenance	73,948		102,249	176,197		176,197	3,034	179,231		6
7	Other (specify):*										7
8	TOTAL General Services	717,788	393,768	307,939	1,419,495		1,419,495	(5,444)	1,414,051		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	3,291,919	265,646	2,100	3,559,665		3,559,665		3,559,665		10
10a	Therapy			908,066	908,066		908,066		908,066		10a
11	Activities	193,170	10,499	3,243	206,912		206,912		206,912		11
12	Social Services	107,083		2,295	109,378		109,378		109,378		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,592,172	276,145	939,704	4,808,021		4,808,021		4,808,021		16
	C. General Administration										
17	Administrative	210,080		443,063	653,143		653,143	(443,063)	210,080		17
18	Directors Fees										18
19	Professional Services			50,090	50,090		50,090	899	50,989		19
20	Dues, Fees, Subscriptions & Promotions			8,452	8,452		8,452	1,949	10,401		20
21	Clerical & General Office Expenses	442,687	31,147	30,902	504,736		504,736	19,566	524,302		21
22	Employee Benefits & Payroll Taxes			625,191	625,191		625,191	72,222	697,413		22
23	Inservice Training & Education			629	629		629		629		23
24	Travel and Seminar			3,030	3,030		3,030	3,232	6,262		24
25	Other Admin. Staff Transportation			250	250		250	10,600	10,850		25
26	Insurance-Prop.Liab.Malpractice			182,644	182,644		182,644	3,522	186,166		26
27	Other (specify):*										27
28	TOTAL General Administration	652,767	31,147	1,344,251	2,028,165		2,028,165	(331,073)	1,697,092		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,962,727	701,060	2,591,894	8,255,681		8,255,681	(336,517)	7,919,164		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			46,124	46,124		46,124	175,603	221,727			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							347,477	347,477			32
33	Real Estate Taxes							561,770	561,770			33
34	Rent-Facility & Grounds			1,752,773	1,752,773		1,752,773	(1,752,773)				34
35	Rent-Equipment & Vehicles			4,440	4,440		4,440	4,868	9,308			35
36	Other (specify):*											36
37	TOTAL Ownership			1,803,337	1,803,337		1,803,337	(663,055)	1,140,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,347	34,714	212,061		212,061		212,061			39
40	Barber and Beauty Shops			25,307	25,307		25,307		25,307			40
41	Coffee and Gift Shops			3,015	3,015		3,015		3,015			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Costs			264,072	264,072		264,072	(264,072)				43
44	TOTAL Special Cost Centers		177,347	449,748	627,095		627,095	(264,072)	363,023			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,962,727	878,407	4,844,979	10,686,113		10,686,113	(1,263,644)	9,422,469			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(23)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(1,702)	4		8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(1,203)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(725)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(250)	43		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(251,092)	43		24
25 Fund Raising, Advertising and Promotional	(8,505)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax	(3,423)	43		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See attached Schedule A	(17,902)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (284,825)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(978,819)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (978,819)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,263,644)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Chicago Ridge

ID# 0042739

Report Period Beginning: 01/01/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/02 - 12/31/02

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collection fees	(9,548)	19
Out of period professional fees	(4,359)	19
Nonallowable Chamber of Commerce dues	(100)	20
Miscellaneous income	(656)	21
Nonallowable miscellaneous expense	(5,139)	21
Deferred maintenance amort.	1,900	6
Total	<u>(17,902)</u>	

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(23)	0	0	0	0	0	0	0	0	0	0	(23)	2
3	Housekeeping	0	0	771	0	0	0	0	0	0	0	0	771	3
4	Laundry	(1,702)	0	0	0	0	0	0	0	0	0	0	(1,702)	4
5	Heat and Other Utilities	0	0	4,117	0	0	0	0	0	0	0	0	4,117	5
6	Maintenance	0	0	1,134	0	0	0	0	0	0	0	0	1,134	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,725)	0	6,022	0	0	0	0	0	0	0	0	4,297	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(443,063)	0	0	0	0	0	0	0	(443,063)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,809	10,680	0	0	0	0	0	0	0	0	21,489	19
20	Fees, Subscriptions & Promotions	0	0	2,049	0	0	0	0	0	0	0	0	2,049	20
21	Clerical & General Office Expenses	0	75	25,286	0	0	0	0	0	0	0	0	25,361	21
22	Employee Benefits & Payroll Taxes	0	0	60,581	0	0	0	0	0	0	0	0	60,581	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,232	0	0	0	0	0	0	0	0	3,232	24
25	Other Admin. Staff Transportation	0	0	0	10,600	0	0	0	0	0	0	0	10,600	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,522	0	0	0	0	0	0	0	3,522	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	10,884	101,828	(428,941)	0	0	0	0	0	0	0	(316,229)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,725)	10,884	107,850	(428,941)	0	0	0	0	0	0	0	(311,932)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	147,047	0	28,556	0	0	0	0	0	0	0	175,603	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,203)	344,059	0	4,621	0	0	0	0	0	0	0	347,477	32
33	Real Estate Taxes	0	552,773	0	2,314	0	0	0	0	0	0	0	555,087	33
34	Rent-Facility & Grounds	0	(1,752,773)	0	0	0	0	0	0	0	0	0	(1,752,773)	34
35	Rent-Equipment & Vehicles	0	0	0	4,868	0	0	0	0	0	0	0	4,868	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,203)	(708,894)	0	40,359	0	0	0	0	0	0	0	(669,738)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(263,995)	(77)	0	0	0	0	0	0	0	0	0	(264,072)	43
44	TOTAL Special Cost Centers	(263,995)	(77)	0	0	0	0	0	0	0	0	0	(264,072)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(266,923)	(698,087)	107,850	(388,582)	0	0	0	0	0	0	0	(1,245,742)	45

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Chicago Ridge		
				Limited Partnership	Chicago Ridge	Real estate ptsp.
See attached Schedule B		See attached Schedule B		Royal Mgmt. Corp	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental expense	\$ 1,752,773	Sambell of Chicago Ridge Limited Partnership	**	\$	\$ (1,752,773)	1
2	V	19 Professional fees		Sambell of Chicago Ridge Limited Partnership	**	10,809	10,809	2
3	V	21 Office supplies expense		Sambell of Chicago Ridge Limited Partnership	**	75	75	3
4	V	30 Depreciation		Sambell of Chicago Ridge Limited Partnership	**	147,047	147,047	4
5	V	32 Interest expense		Sambell of Chicago Ridge Limited Partnership	**	340,850	340,850	5
6	V	32 Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	3,209	3,209	6
7	V	33 Property taxes		Sambell of Chicago Ridge Limited Partnership	**	552,773	552,773	7
8	V	43 State replacement tax	77	Sambell of Chicago Ridge Limited Partnership	**		(77)	8
9	V							9
10	V							10
11	V			** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V			of Sambell of Chicago Ridge Limited Partnership				12
13	V							13
14	Total		\$ 1,752,850			\$ 1,054,763	\$ * (698,087)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/02 - 12/31/02

Schedule B

VII. Related Parties
Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/02

Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 771	\$ 771
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,921	3,921
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	196	196
18	V	6 Repairs & maintenance		Royal Management Corp.	**	1,068	1,068
19	V	6 Scavenger & exterminating		Royal Management Corp.	**	49	49
20	V	6 Security service		Royal Management Corp.	**	17	17
21	V	19 Computer consultant & supplies		Royal Management Corp.	**	8,509	8,509
22	V	19 Professional fees		Royal Management Corp.	**	2,171	2,171
23	V	20 Advertising - help wanted		Royal Management Corp.	**	1,232	1,232
24	V	20 Dues & subscriptions		Royal Management Corp.	**	817	817
25	V	21 Bank charges		Royal Management Corp.	**	2,839	2,839
26	V	21 Communications		Royal Management Corp.	**	567	567
27	V	21 Office supplies & printing		Royal Management Corp.	**	10,757	10,757
28	V	21 Postage		Royal Management Corp.	**	3,379	3,379
29	V	21 Telephone		Royal Management Corp.	**	7,744	7,744
30	V	22 FICA		Royal Management Corp.	**	32,654	32,654
31	V	22 FUTA		Royal Management Corp.	**	601	601
32	V	22 SUTA		Royal Management Corp.	**	655	655
33	V	22 Insurance - W/C		Royal Management Corp.	**	757	757
34	V	22 Insurance - hospitalization		Royal Management Corp.	**	18,994	18,994
35	V	22 401(k) and other emp. benefits		Royal Management Corp.	**	6,920	6,920
36	V	24 Travel & seminar		Royal Management Corp.	**	3,232	3,232
37	V						
38	V	**Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 107,850	\$ * 107,850

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/02

Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	25 Auto expense	\$	Royal Management Corp.	**	\$ 10,600	\$ 10,600
16	V	26 Insurance - general		Royal Management Corp.	**	3,522	3,522
17	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,781	3,781
18	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	7,425	7,425
19	V	30 Depreciation - equipment		Royal Management Corp.	**	17,350	17,350
20	V	32 Interest		Royal Management Corp.	**	4,621	4,621
21	V	33 Property taxes		Royal Management Corp.	**	2,314	2,314
22	V	35 Equipment rental		Royal Management Corp.	**	4,868	4,868
23	V	17 Management fees	443,063	Royal Management Corp.	**		(443,063)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	**Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 443,063			\$ 54,481	\$ * (388,582)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	5	11%	Salary	\$ 39,901	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	10%	Salary	17,734	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	10%	Salary	22,167	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10%	Salary	5,320	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12%	Salary	13,437	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 98,559		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/02 - 12/31/02

Schedule C

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	13,617	30,638	17,021	4,085	10,318	75,679
Lexington Health Care Center of Elmhurst, Inc.	11,875	26,719	14,844	3,563	8,998	65,999
Lexington Health Care Center of LaGrange, Inc.	8,629	19,416	10,787	2,589	6,538	47,959
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Lombard, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Orland Park, Inc.	21,376	48,096	26,721	6,413	16,194	118,800
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Streamwood, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Wheeling, Inc.	17,496	39,367	21,870	5,249	13,258	97,240
Total	142,266	320,099	177,833	42,680	107,794	790,672

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/02Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	\$ 6,954	\$	81,760	771	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380		81,760	3,921	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765		81,760	196	3
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640		81,760	1,068	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	438		81,760	49	5
6	6	Security service	Bed Days	737,665	10	150		81,760	17	6
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767		81,760	8,509	7
8	19	Professional fees	Bed Days	737,665	10	19,590		81,760	2,171	8
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111		81,760	1,232	9
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373		81,760	817	10
11	21	Bank charges	Bed Days	737,665	10	25,613		81,760	2,839	11
12	21	Communications	Bed Days	737,665	10	5,118		81,760	567	12
13	21	Office supplies & printing	Bed Days	737,665	10	97,051		81,760	10,757	13
14	21	Postage	Bed Days	737,665	10	30,484		81,760	3,379	14
15	21	Telephone	Bed Days	737,665	10	69,873		81,760	7,744	15
16	22	FICA	Bed Days	737,665	10	294,613		81,760	32,654	16
17	22	FUTA	Bed Days	737,665	10	5,419		81,760	601	17
18	22	SUTA	Bed Days	737,665	10	5,907		81,760	655	18
19	22	Insurance - W/C	Bed Days	737,665	10	6,829		81,760	757	19
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371		81,760	18,994	20
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427		81,760	6,920	21
22	24	Travel & seminar	Bed Days	737,665	10	29,161		81,760	3,232	22
23										23
24										24
25	TOTALS					\$ 973,034	\$		\$ 107,850	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/02Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	\$ 95,636	\$ 81,760	\$ 10,600	1
2	26	Insurance - general	Bed Days	737,665	10	31,776	81,760	3,522	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112	81,760	3,781	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995	81,760	7,425	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541	81,760	17,350	5
6	32	Interest	Bed Days	737,665	10	41,692	81,760	4,621	6
7	33	Property taxes	Bed Days	737,665	10	20,881	81,760	2,314	7
8	35	Equipment rental	Bed Days	737,665	10	43,917	81,760	4,868	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 491,550	\$	\$ 54,481	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Lexington Financial						\$					\$	1	
2	Services II, L.L.C.	X		Mortgage	\$42,300.00	12/29/98	5,563,000	4,972,718	01/01/08	0.0675	340,850		2	
3													3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related				\$42,300.00		\$ 5,563,000	\$ 4,972,718				\$ 340,850	9	
	B. Non-Facility Related*													
10								Amortization of mortgage costs			3,209	10		
11								Interest income offset			(1,203)	11		
12								Allocated from management company			4,621	12		
13													13	
14	TOTAL Non-Facility Related						\$						\$ 6,627	14
15	TOTALS (line 9+line14)						\$ 5,563,000	\$ 4,972,718				\$ 347,477	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lexington of Chicago Ridge**# **0042739**Report Period Beginning: **01/01/02**

Ending:

12/31/02**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	492,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		Allocation from management company	\$	2,314	
		2001	\$	499,417	2
3. Under or (over) accrual (line 2 minus line 1).			\$	9,731	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	547,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	6,683	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ 1,644 For 1995 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(1,644)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	561,770	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1997	404,097	8
	1998	442,475	9
	1999	462,509	10
	2000	478,861	11
	2001	499,417	12

2001 taxes:	499,417		
Estimated increase (1.095%):	1,095		
Estimated 2002 taxes:	546,861		
Use:	547,000		

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Chicago Ridg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042739

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-18-200-030-0000</u>	<u>Land and building</u>	\$ <u>488,391.39</u>	\$ <u>488,391.39</u>
2. <u>24-07-311-012-0000</u>	<u>Land and building</u>	\$ <u>11,025.35</u>	\$ <u>11,025.35</u>
3. <u>Royal Management Corp. (Omni Partners)</u>		\$	\$
4. <u>06-19-201-018</u>	<u>Land and building</u>	\$ <u>70,162.04</u>	\$ <u>162.00</u>
5. <u>Royal Management Corp. (Samvest</u>		\$	\$
6. <u>05-01-202-019</u>	<u>Land and building</u>	\$ <u>144,399.49</u>	\$ <u>2,152.00</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>713,978.27</u>	\$ <u>501,730.74</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

A. Square Feet:

85,551

B. General Construction Type:

Exterior

Concrete Block

Frame

Steel

Number of Stories

3

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	31,000	1989	\$ 505,000	1
2	Allocation from management company			18,045	2
3	TOTALS	31,000		\$ 523,045	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	215	1991	1991	\$ 5,143,342	\$	35	\$ 146,953	\$ 146,953	\$ 1,702,202
5	9	1995	1995	97,352	2,781	35	2,781		20,861
6									
7									
8									
Improvement Type**									
9	Leasehold Improvements	1993		2,694	78	35	78		732
10	Leasehold Improvements	1994		6,581	188	35	188		1,598
11	Dishwasher hood	1996		2,480	248	10	248		1,612
12	Lobby repairs	1996		8,698	870	10	870		5,654
13	Basement rehab	1997		24,477	2,448	10	2,448		14,278
14	Wiring	1998		3,428	343	10	343		1,543
15	Handrails	1998		895	60	15	60		269
16	Resurface & restripe parking lot	1998		4,450	445	10	445		2,002
17	Fire wall	1998		2,169	62	35	62		279
18	Foyer floor tile	1999		32,379	3,238	10	3,238		12,412
19	Wallpapering / painting / decorating	1999		8,833	883	10	883		2,871
20	Rebuild garage area	1999		1,762	50	35	50		159
21	Roof repairs	2000		6,240	624	10	624		1,560
22	Electrical wiring	2000		3,986	114	35	114		285
23	Electrical wiring	2000		2,536	72	35	72		181
24	Kitchen rehab	2000		6,623	221	35	221		552
25	Automatic doors	2000		1,300	130	10	130		325
26	Elevator eye sensors	2000		4,500	300	15	300		750
27	Resurface & restripe parking lot	2001		3,319	332	10	332		498
28	Door releases	2001		5,200	520	10	520		780
29	Carpeting	2001		10,022	1,002	10	1,002		1,503
30	Roof repairs	2002		25,600	1,067	20	1,067		1,067
31	Elevator upgrade	2002		9,866	575	10	575		575
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Leasehold improvements - management company	1995	\$ 11,437	\$	35	\$ 415	\$ 415	\$ 2,451	37
38	Leasehold improvements - management company	1996	9,308		35	338	338	1,729	38
39	Leasehold improvements - management company	1989	321		31	12	12	151	39
40	HVAC - management company	1998	241		35	9	9	34	40
41	Offices - management company	1999	608		35	22	22	61	41
42	Offices - management company	2000	289		35	10	10	23	42
43	Land improvements - management company	2002	10,824		15	661	661	661	43
44	Building - management company	2002	252,340		40	5,783	5,783	5,783	44
45	Sewer & water improvements - management company	2002	5,740		30	175	175	175	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,709,840	\$ 16,651		\$ 171,029	\$ 154,378	\$ 1,785,616	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 221,253	\$ 28,855	\$ 28,949	\$ 94	5-10 years	\$ 134,645	71
72	Current Year Purchases	7,649	618	618		5-10 years	619	72
73	Fully Depreciated Assets	395,742					395,742	73
74	Allocated from Mgmt Co.	173,290		17,350	17,350		45,327	74
75	TOTALS	\$ 797,934	\$ 29,473	\$ 46,917	\$ 17,444		\$ 576,333	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	1994 Infiniti	1994	\$ 19,313	\$	\$	\$	5	\$ 19,313	76
77										77
78										78
79	Allocated from Mgmt Co.			33,843		3,781	3,781		23,551	79
80	TOTALS			\$ 53,156	\$	\$ 3,781	\$ 3,781		\$ 42,864	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,083,975	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,124	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 221,727	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 175,603	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,404,813	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Redecorate common rooms	\$ 64,898	92
93			93
94			94
95		\$ 64,898	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

☐ YES ☐ NO

14. /2005 \$

(Attach a schedule detailing the breakdown of movable equipment)

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	34,589	\$ 400,770	\$	34,589	\$ 400,770	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		619	12,324		619	12,324	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		46,864	494,972		46,864	494,972	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				177,347		177,347	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					34,714			34,714	13
14	TOTAL			\$	82,072	\$ 942,780	\$ 177,347	82,072	\$ 1,120,127	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Chicago Ridge

Provider #: 0042739

01/01/02 to 12/31/02

Schedule D

XIV. Special Services

Line 13, Other:

Service	Cost	Line Reference
Oxygen	11,562	L39, C3
Radiology	10,315	L39, C3
Laboratory	3,234	L39, C3
Clinitron Beds	9,603	L39, C3
Total	<u>34,714</u>	

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/02

Ending:

12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 17,631	\$ 33,468	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 815,603)	2,229,534	2,235,274	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,196	51,196	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	63,074	63,074	8
9	Other(specify): Escrow		118,738	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,361,435	\$ 2,501,750	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,943	6,943	12
13	Land		523,045	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	275,390	566,498	15
16	Equipment, at Historical Cost	234,543	851,090	16
17	Accumulated Depreciation (book methods)	(216,321)	(2,404,813)	17
18	Deferred Charges		951	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Construction in progress	64,898	64,898	22
23	Other(specify): Unamortized Mortgage Costs		51,337	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 365,453	\$ 4,803,291	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,726,888	\$ 7,305,041	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 386,721	\$ 386,721	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	386,055	386,055	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	326,832	326,832	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,373	1,373	31
32	Accrued Real Estate Taxes(Sch.IX-B)		547,000	32
33	Accrued Interest Payable		27,972	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	653,458	175,373	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,754,439	\$ 1,851,326	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,972,718	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,972,718	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,754,439	\$ 6,824,044	46
47	TOTAL EQUITY (page 18, line 24)	\$ 972,449	\$ 480,997	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,726,888	\$ 7,305,041	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/02 - 12/31/02

Schedule E

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued rent	478,085	-
Accrued management fees	76,259	76,259
Accrued 401(k) contribution	26,754	26,754
Accrued 401(k) withholding	12,245	12,245
Due to related party	15,484	15,484
Other accrued expenses	44,631	44,631
	<hr/>	<hr/>
Total line 36	<u>653,458</u>	<u>175,373</u>

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Investment Income in Lexington Financial Services II, LLC	872
State bedhold Income	26,348
Miscellaneous Income	656
	<hr/>
Total line 28	<u>27,876</u>

See Accountants' Compilation Report

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,382,466	1
2	Restatements (describe):		2
3	Prior period adjustment	(157,765)	3
4	Prior year's post closing entries	(95,309)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,129,392	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	670,057	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,827,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,156,943)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 972,449	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/02

Ending:

12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,138,428	1
2	Discounts and Allowances for all Levels	(762,422)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,376,006	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,633,174	6
7	Oxygen	329	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,633,503	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,670	12
13	Barber and Beauty Care	29,137	13
14	Non-Patient Meals	23	14
15	Telephone, Television and Radio	73	15
16	Rental of Facility Space		16
17	Sale of Drugs	209,355	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,080	19
20	Radiology and X-Ray	10,315	20
21	Other Medical Services	44,227	21
22	Laundry	1,702	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 317,582	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,203	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,203	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	27,876	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,876	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,356,170	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,419,495	31
32	Health Care	4,808,021	32
33	General Administration	2,028,165	33
B. Capital Expense			
34	Ownership	1,803,337	34
C. Ancillary Expense			
35	Special Cost Centers	504,455	35
36	Provider Participation Fee	122,640	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,686,113	40
41	Income before Income Taxes (line 30 minus line 40)**	670,057	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 670,057	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files a cash basis tax return

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lexington of Chicago Ridge**# **0042739**Report Period Beginning: **01/01/02**Ending: **12/31/02**

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,215	2,350	\$ 111,082	\$ 47.27	1
2	Assistant Director of Nursing	4,094	4,207	135,232	32.14	2
3	Registered Nurses	57,829	62,572	1,604,948	25.65	3
4	Licensed Practical Nurses	3,802	4,314	97,743	22.66	4
5	Nurse Aides & Orderlies	100,982	106,517	1,213,323	11.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,771	10,713	129,591	12.10	8
9	Activity Director	1,976	2,080	26,500	12.74	9
10	Activity Assistants	16,210	17,178	166,670	9.70	10
11	Social Service Workers	5,837	5,837	107,083	18.35	11
12	Dietician					12
13	Food Service Supervisor	2,062	2,277	23,024	10.11	13
14	Head Cook	1,914	2,074	21,181	10.21	14
15	Cook Helpers/Assistants	15,297	16,429	149,659	9.11	15
16	Dishwashers	16,324	16,964	104,688	6.17	16
17	Maintenance Workers	4,135	4,457	73,948	16.59	17
18	Housekeepers	37,554	40,010	274,190	6.85	18
19	Laundry	10,254	10,882	71,098	6.53	19
20	Administrator	2,243	2,361	111,521	47.23	20
21	Assistant Administrator					21
22	Other Administrative	737	737	98,559	133.73	22
23	Office Manager					23
24	Clerical	22,619	24,078	442,687	18.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	315,855	336,037	\$ 4,962,727 *	\$ 14.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	249	\$ 15,513	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	13	625	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	69	3,243	L11, C3	44
45	Social Service Consultant	51	2,295	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	382	\$ 46,876		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lexington of Chicago Ridge**# **0042739**Report Period Beginning: **01/01/02**Ending: **12/31/02****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership %	Amount	D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function			Description	Amount	Description	Amount	
Linda Cecconi	Administrator	0.00%	\$ 111,521	Workers' Compensation Insurance	\$ 90,080	IDPH License Fee	\$	
John Samatas	Admin/Plant Ops	22.33%	17,734	Unemployment Compensation Insurance	25,388	Advertising: Employee Recruitment	5,120	
James Samatas	Administrative	22.33%	39,901	FICA Taxes	364,129	Health Care Worker Background Check (Indicate # of checks performed <u>13</u>)	156	
Cynthia Thiem	Administrative	22.34%	22,167	Employee Health Insurance	165,250	Miscellaneous Dues & Subs	1,123	
George Samatas	Administrative	0.00%	5,320	Employee Meals	11,641	Miscellaneous Licenses & Permits	1,953	
Jason Samatas	Administrative	0.00%	13,437	Illinois Municipal Retirement Fund (IMRF)* 401(k) Contributions	30,129			
				Other Employee Benefits	10,796			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 210,080			Allocated from management company	2,049	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management fees (eliminated in column 7)			\$ 443,063			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 443,063	TOTAL (agree to Schedule V, line 22, col.8)	\$ 697,413	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,401	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ING	401(k) Administration		\$ 750				Out-of-State Travel	\$
Altschuler, Melvoin & Glasser LLP	Accounting		14,680					
American Express Tax & Bus. Svcs.	Accounting		5,468	N/A			In-State Travel	
Global Care Consulting	Consulting		3,979					
Internet Presence Consulting	Computer Consultant		711					
James Samatas	Legal		50					
Personnel Planners	U/C Consulting		1,065				Seminar Expense	3,030
Carol Jeschke	Staffing Consultant		738				See attached detail	
Sachnoff & Weaver	Legal		2,316					
Systematic Management	Billing Consulting		115				Allocated from management company	3,232
Harris, Kessler & Goldstein	Legal		4,178				Entertainment Expense	()
See attached Schedule F			16,040				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 50,090	TOTAL		\$	TOTAL	\$ 6,262

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Chicago Ridge, Inc.
 Provider # 0036996
 1/1/02 - 12/31/02

Schedule F

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Freedman, Anselmo & Lindberg	Collections	9,548
Katten Muchin Zavis Rosenman	Legal	868
Glantz-Richman	Rehabilitation Consultant	350
Christ Hospital	Consulting	381
Advanced Answers on Demand, Inc.	Computer Services	3,247
Action Computer Service Inc.	Computer Services	324
Gigatrend	Computer Services	195
Telenet Communication	Computer Services	260
Information Controls, Inc.	Computer Services	867
		<u>16,040</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u>50,090</u>
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	808
Brekke Consulting, Inc.	Exec. Counsel Consulting	187
Gilson, Labus and Silverman	Accounting	50
James Samatas	Legal	22
Katten, Muchin, Zavis and Rosenman	Legal	245
Sachnoff and Weaver	Legal	134
ING / Pension Administrators / Aetna Life Insurance & Annuity Co.	401 (k) Administration	600
Various	Consulting	8,634
Allocated from building partnership		
James Samatas	Filing and recording fees	126
McCracken, Walsh, de Lavan & Hetler	Real estate appraisal fees	6,683
LaSalle Appraisal Group, Inc.	Consulting	4,000
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Collection fees	(9,548)
Out of period professional fees		
Christ Hospital	Out of period	(381)
Global Care Consulting Service	Out of period	(3,978)
Reclassifications		
McCracken, Walsh, de Lavan & Hetler	Real estate appraisal fees	(6,683)
Total, Agrees to Schedule V, Line 19, Column 8		<u>50,989</u>

See accountants' compilation report.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Deferred painting & dec	12/99	\$ 2,198	3 years	\$	\$ 367	\$ 732	\$ 732	\$ 367	\$	\$	\$	\$
2	Deferred painting & dec	12/00	3,503	3 years		583	1,168	1,168	584				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,701		\$	\$ 950	\$ 1,900	\$ 1,900	\$ 951	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 74,287 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 122,640
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 11,641 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 23
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service: performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Lexington of Chicago Ric

03:21 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,263,644	equal to	-1,263,644	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	347,477	equal to	347,477	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	561,770	equal to	561,770	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	221,727	equal to	221,727	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	9,308	equal to	9,308	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	908,066	equal to	908,066	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	177,347	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,419,495	equal to	1,419,495	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,808,021	equal to	4,808,021	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,028,165	equal to	2,028,165	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,803,337	equal to	1,803,337	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	504,455	equal to	504,455	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,162,328	equal to	3,291,919	-129,591	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	193,170	equal to	193,170	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	107,083	equal to	107,083	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	298,552	equal to	298,552	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	73,948	equal to	73,948	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	274,190	equal to	274,190	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	71,098	equal to	71,098	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	210,080	equal to	210,080	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	442,687	equal to	442,687	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,962,727	equal to	4,962,727	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	15,513	< or = to	15,642	-129	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,000	< or = to	24,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,825	< or = to	2,100	-275	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,243	< or = to	3,243	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,295	< or = to	2,295	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	210,080	equal to	210,080	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	443,063	equal to	443,063	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	50,090	equal to	50,090	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	697,413	equal to	697,413	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	10,401	equal to	10,401	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,262	equal to	6,262	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	11,641	< or = to	72,222	-60,581	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	11,641	equal to	11,641	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	8,065	equal to	8,895	-830	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-978,819	equal to	-978,819	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	4,972,718	equal to	4,972,718	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	547,000	equal to	547,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	523,045	equal to	523,045	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,709,840	equal to	5,709,840	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	851,090	equal to	851,090	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,404,813	equal to	2,404,813	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	972,449	equal to	972,449	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	670,057	equal to	670,057	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	951	equal to	951	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,726,888	equal to	2,726,888	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	298,552	31,237	15,642	345,431	0	345,431	0	345,431
2. Food P	0	293,602	0	293,602	0	293,602	-11,664	281,938
3. Housek	274,190	45,364	0	319,554	0	319,554	771	320,325
4. Laundry	71,098	23,565	0	94,663	0	94,663	-1,702	92,961
5. Heat ar	0	0	190,048	190,048	0	190,048	4,117	194,165
6. Mainte	73,948	0	102,249	176,197	0	176,197	3,034	179,231
7. Other (0	0	0	0	0	0	0	0
8. Total G	717,788	393,768	307,939	1,419,495	0	1,419,495	-5,444	1,414,051
9. Medical	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursin	3,291,919	265,646	2,100	3,559,665	0	3,559,665	0	3,559,665
10a. Ther	0	0	908,066	908,066	0	908,066	0	908,066
11. Activi	193,170	10,499	3,243	206,912	0	206,912	0	206,912
12. Social	107,083	0	2,295	109,378	0	109,378	0	109,378
13. Nurse	0	0	0	0	0	0	0	0
14. Progr	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	3,592,172	276,145	939,704	4,808,021	0	4,808,021	0	4,808,021
17. Admin	210,080	0	443,063	653,143	0	653,143	-443,063	210,080
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	50,090	50,090	0	50,090	899	50,989
20. Fees,	0	0	8,452	8,452	0	8,452	1,949	10,401
21. Cleric	442,687	31,147	30,902	504,736	0	504,736	19,566	524,302
22. Emplo	0	0	625,191	625,191	0	625,191	72,222	697,413
23. Inserv	0	0	629	629	0	629	0	629
24. Travel	0	0	3,030	3,030	0	3,030	3,232	6,262
25. Other	0	0	250	250	0	250	10,600	10,850
26. Insura	0	0	182,644	182,644	0	182,644	3,522	186,166
27. Other	0	0	0	0	0	0	0	0
28. Total C	652,767	31,147	1,344,251	2,028,165	0	2,028,165	-331,073	1,697,092
29. Total C	4,962,727	701,060	2,591,894	8,255,681	0	8,255,681	-336,517	7,919,164
30. Depre	0	0	46,124	46,124	0	46,124	175,603	221,727
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	0	0	0	0	347,477	347,477
33. Real E	0	0	0	0	0	0	561,770	561,770
34. Rent -	0	0	1,752,773	1,752,773	0	1,752,773	#####	0
35. Rent -	0	0	4,440	4,440	0	4,440	4,868	9,308
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	1,803,337	1,803,337	0	1,803,337	-663,055	1,140,282
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	177,347	34,714	212,061	0	212,061	0	212,061
40. Barbe	0	0	25,307	25,307	0	25,307	0	25,307
41. Coffee	0	0	3,015	3,015	0	3,015	0	3,015
42. Provid	0	0	122,640	122,640	0	122,640	0	122,640
43. Other	0	0	264,072	264,072	0	264,072	-264,072	0
44. Total S	0	177,347	449,748	627,095	0	627,095	-264,072	363,023
45. Grand	4,962,727	878,407	4,844,979	#####	0	#####	#####	9,422,469

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	17,631	33,468
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	2,229,534	2,235,274
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	51,196	51,196
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	63,074	63,074
9. Other (specify):	0	118,738
10. Total current assets	2,361,435	2,501,750
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	6,943	6,943
13. Land	0	523,045
14. Buildings, at Historical Cost	0	5,143,342
15. Leasehold Improvements, Historical Cost	275,390	566,498
16. Equipment, at Historical Cost	234,543	851,090
17. Accumulated Depreciation (book methods)	-216,321	-2,404,813
18. Deferred Charges	0	951
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	64,898	64,898
23. other (specify):	0	51,337
24. Total Long-Term Assets	365,453	4,803,291
25. Total Assets	2,726,888	7,305,041
CURRENT LIABILITIES		
26. Accounts Payable	386,721	386,721
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	386,055	386,055
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	326,832	326,832
31. Accrued Taxes Payable	1,373	1,373
32. Accrued Real Estate Taxes	0	547,000
33. Accrued Interest Payable	0	27,972
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	653,458	175,373
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,754,439	1,851,326
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	4,972,718
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	4,972,718
46. Total Liabilities	1,754,439	6,824,044
47. Total Equity	972,449	480,997
48. Total Liabilities and Equity	2,726,888	7,305,041

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,138,428
2. Discounts and Allowances for all Levels	-762,422
Subtotal - Inpatient Care	9,376,006
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,633,174
7. Oxygen	329
Subtotal - Ancillary Revenue	1,633,503
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	2,670
13. Barber and Beauty Care	29,137
14. Non-Patient Meals	23
15. Telephone, Television, and Radio	73
16. Rental of Facility Space	0
17. Sale of Drugs	209,355
18. Sale of Supplies to Non-Patients	0
19. Laboratory	20,080
20. Radiology and X-Ray	10,315
21. Other Medical Services	44,227
22. Laundry	1,702
Subtotal - Other Operating Revenue	317,582
24. Contributions	0
25. Interest and Other Investments Income	1,203
Subtotal - Non-Operating Revenue	1,203
27. Other Revenue (specify):	27,876
28. Other Revenue (specify):	0
Subtotal - Other Revenue	27,876
30. Total Revenue	11,356,170
31. General Services	1,419,495
32. Health Care	4,808,021
33. General Administration	2,028,165
34. Ownership	1,803,337
35. Special Cost Centers	504,455
35. Provider Participation Fee	122,640
37. Other	0
40. Total Expenses	10,686,113
41. Income Before Income Taxes	670,057
42. Income Taxes	0
43. Net Income or Loss for the Year	670,057

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9 Line 16 for mortgage insurance.

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